

SENT VIA EMAIL OR FAX ON
Apr/21/2009

Applied Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/21/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior Lumbar Interbody Fusion L4/5 and L5/S1, Posterior Lumbar Decompression with Posterolateral Fusion and Pedicle Screw Instrumentation L4/5 and L5/S1.

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Office notes, Dr. 8/1/07, 12/09/08, 01/28/09

Office notes, Dr., 8/23/07, 09/27/07

Procedure report, Dr, 9/5/07

Progress notes, 11/3/08

Pre-surgical psych screening, , 12/31/08

Flexion/extension X-rays, 1/14/09

Discogram, 1/15/09

CT scan, 1/15/09

MRI lumbar spine, 3/3/09

Peer review, Dr., 3/10/09

Peer review, Dr., 3/23/09

IRO appeal, Dr.

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female with a diagnosis of lumbar mechanical/discogenic pain syndrome at L4-5 and L5-S1, lumbar radiculitis, lumbar disc displacement and lumbago. The date of

injury was xx-xx-xx and the claimant has been treating with Dr. for low back pain and pain radiating mainly to the right lower extremity along the lateral thigh and calf and intermittently into dorsum and lateral aspect of the right foot. The low back pain was noted to be worse than the leg pain. On 08/01/07 Dr. indicated that the claimant had been treated with physical therapy with no improvement. It was noted that an MRI from 04/30/07 demonstrated disc protrusion broad based at L5-S1 with a right sided annular tear, decreased disc height and disc desiccation. At L4-5 there was a 2 mm disc protrusion again with a central annular tear, decreased disc height and disc desiccation. An epidural steroid injection was given on 09/05/07 with temporary improvement.

The records lapse until 12/09/08 at which time Dr. noted that the claimant had failed physical therapy, epidural steroid injection, facet injections and rhizotomy. On exam she had 4/5 strength in the tibialis anterior and gastroc on the right. Reflexes were 1+ in the right ankle, otherwise 2+. The claimant had difficulty with toe and heel walking. Straight leg raise was positive on the right, right at 45 degrees. There was a hypoesthetic region in both L5 and S1 distributions.

A pre surgical psychological screening was done on 12/31/08, which cleared the claimant for discogram and surgery. Flexion/extension films on 01/14/09 did not show any subluxation with flexion, extension, left and right bending. Discography on 01/15/09 showed severe concordant pain at L5-S1, moderate to severe concordant pain at L4-5 and moderate concordant pain at L3-4.

On 01/28/09 Dr. noted no improvement and no change in exam findings. He indicated that the CT/discogram demonstrated severe concordant pain at L4-5 and L5-S1 and nonconcordant pain at L3-4. He recommended anterior lumbar interbody fusion at L4-5 and L5-S1, posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation at L4-5 and L5-S1. A repeat lumbar MRI was done on 03/03/09. The surgery has been denied twice on peer review. Dr. authored an appeal letter indicating that the claimant meets ODG criteria.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

Anterior lumbar interbody fusion at L4-5 and L5-S1 and posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation at L4-5 and L5-S1 is not indicated and appropriate.

This is a who is noted to have at CT scan post discogram on 01/15/09 which demonstrates a disc tear at L5-S1 and degeneration at L4-5. The discogram noted severe concordant pain at L5-S1, L4-5, and L3-4 without any evidence of control level. Flexion/extension radiographs did not demonstrate any instability. There has been psychological testing which demonstrates good prognosis. Objectively there is weakness documented on 12/09/08 with 4/5 strength of the tibialis anterior and gastrocnemius soleus, difficulty walking and nerve tension signs and straight leg raising, and decreased sensibility. An MRI on 03/03/09 demonstrates a left paracentral disc protrusion at L5-S1 and a 3 millimeter posterior central disc protrusion at L4-5 mildly impinging upon the thecal sac with degenerative change. There is also no evidence of tumor, instability or infection. There is no indication for fusion surgery based on the records reviewed.

Official Disability Guidelines Treatment in Worker's Comp 2009 Update

Patient Selection Criteria for Lumbar Spinal Fusion:

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

- AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)